diseases or health problems, the following list is given:

Disease/health problem	Medicine/treatment
1. Cramps	1. Distilled herbs (chor araq)
2. Gas in the stomach	2. Halila and zanjabil (ginger) in powdered form
3. Colds	3. Several boiled herbs
4. Leg pains	4. Sofoof sodenjan
5. Bad qawin	5. The oil of two plants - sharsham (linseed) and zarserski
6. Nervous problems	6. Mixture of almond, cardamon, opium, rayham seeds, kasni seeds
7. Heart murmuring	7. Boiled and strained Russian olive with sugar
8. Wounds	8. Put a leach on the wound to suck the pus and blood

Obtaining the herbs: Most of the hakims' medicines are of a plant base. These plants may be gathered locally by individuals who then sell them to hakims. They may also be purchased from atars or the atar bazaar where there are substances from India, Pakistan, Iran and the Arabic countries. Other chemicals and minerals used by the hakims may be found locally in shops.

From these substances the hakims then prepare their medicinal combinations.

Clientele of the Hakims:

The hakim's patients are from all classes of the society. However, those who frequent him most are those who cannot afford or are not used to the modern medical practitioners' ways. Women

are among those who frequent the <u>hakim</u>'s shop regularly. This may be explained in that a woman may remain in <u>chadri</u> (<u>purda</u>) when going to the <u>hakim</u>, but when she goes to a doctor she is asked to have an examination. Also the women may frequently be picking up medicines for the family or children as well as herself. Of course the wealthier, more educated people frequent the doctors, but still may on occasion pick up substances from the <u>hakim</u>'s shop.

The <u>hakim</u> is careful to not make the medicine too expensive for the purchaser. Usually he gives the patient an idea in advance of how much the medicines and treatment will cost. In this case the patient knows ahead of time whether or not he will be able to afford such. If the patient doesn't have enough money to pay the full amount the <u>hakim</u> will just charge him half, give him half of the medicine, and tell him to return for the remainder of the medicine when he can pay for it. The patient may like this arrangement as he can first see whether the medicine is effective before he buys more and he also may have more time to pay if he doesn't happen to have sufficient funds.

The <u>hakim</u>'s business is busiest in the spring and summer. In the winter the amount of clients decreases to approximately three to five patients per day. In the other seasons he may have fifteen to twenty patients per day.

The <u>hakims</u> may also receive patients that are sent from other sources. <u>Atars</u> send patients to <u>hakims</u> for the purpose of having

their problem diagnosed. Also dais, traditional birth attendants (See Section E, page 44), may frequent the hakims in certain areas to pick up substances for the women they are serving. These substances may be for treating fertility regulation problems or medicines relating to the mother's pre-natal or post-partum health. Modern medical practitioners are not in the habit of referring their patients to the hakims for assistance.

Cost of Medicine/Services:

The hakims receive an income paid to them directly by their patients for the treatment received. The medicinal preparations are much cheaper than those purchased in the modern pharmacy; usually the charge ranges from fifty to 120 afghanis[1/] although many treatments may be cheaper than this rate.

The patient load of the hakims increases in the summer when more people are bothered by digestive difficulties due to the availability of fresh fruits and vegetables. This enables the hakims to receive more income at this time; it was said that one famous hakim easily received a daily income of more than 1000 afghanis.

The income of the hakim generally allows his living standard to be average or above.

1/ 1 afghani = 1.8 US cents at 55.5 afghanis to the US dollar, April 1975.

Position in the Traditional Health Services System of the Country:

The *hakims* perform a very necessary service through their diagnosis of illness and distribution of indigenous medicine. A city or community may have numerous *hakim* shops; for example it is estimated that Charikar has approximately ten *hakims*.

There is a lack of modern physicians throughout the country and the fees charged by those who do exist are often prohibitive for much of the population; some relate that doctors do not have enough time to give their patients individual treatment. In addition, many individuals of a traditional orientation do ~~not~~ trust modern medicine. Thus, the role of the *hakim* is one of prime importance for many.

Relationships With/Attitudes Towards Other Medical Practitioners (Traditional and Modern):

The *hakims* are believers in traditional medicine and feel in general that their work is dependable providing they know their job well and work carefully. *Hakims* are on good terms with other *hakims* and also have good working relationships with ~~the~~ *atars* from whom they pick up many of their medicines.

As far as the other traditional practitioners are concerned, the *hakim* seems to have the most faith in the work of the *dai* (traditional birth attendant - Section E, page 44) and the *shikastaband* (boensetter - Section C, page 25). He does not show such faith in the work of the various *dalaks* (circumcisors/blood-

letters - Section D, page 31) or the amulet-makers (Section F, page 52).

The <u>hakims</u> do not have a negative attitude towards the modern medical practitioners and their treatments in general. They believe that when a doctor is well trained their services in the area of surgery, TB, heart ailments, etc., are beneficial and good. They think that modern medicine is beneficial when the doctors diagnose the disease correctly and prescribe the correct medicines. They do recognize the services of the doctor as being expensive and relate that these services are therefore not available to everyone. For this reason it is also fortunate the <u>hakim</u> exists.

<u>Opinion of General Health of the Community Today in Comparison to the Past</u>:

The opinion of many <u>hakims</u> was that the health of the community is worse presently than it has been in the past. They feel that the conditions caused by greater population and the resulting crowding has caused some of these problems. They said they thought there were more types of diseases these days than in the past. They felt that people lived longer in the past.

<u>History and Future of Their Work</u>:

It is believed that the profession of the <u>hakims</u> originated in Greece. It has also picked up some content from the Indian subcontinent where the practice of traditional medicine is widespread. It is said that Loqmani Hakim was the first <u>hakim</u>. He was of Greek origin and he himself never came to Afghanistan. The

profession became widespread in Afghanistan when King Sultan Mahmood (11th century) gathered several hakims and asked them to write a book of their medicine. At that time, under the patronage of the king, many books on Greek, or traditional, medicine were written.

Present day hakims feel that their profession has improved over time. They say there are more medicines and more diseases known to them now than there were before. Also in the past, they say, the hakims were not able to distill substances or undertake other processes employed in the trade today.

In regards to the future of their profession the hakims expressed a pessimistic point of view. They feared that with the increased activity and acceptance of modern medicine such would predominate and cause the demise of the hakims' business.

Suggestions for Future Programs:

Hakims could be trained in the basics of family planning and serve as counsellors on the subject in addition to participating in the distribution of contraceptives - the condom, creams, jellies, and perhaps the pill. At present individuals refer to the hakims concerning family planning and thus such a program seems feasible. This could be conducted by the Afghan Family Guidance Association perhaps with a grant from US/AID.

This distribution by hakims would save the Afghan Family Guidance Association clinics from experiencing patient overloads

by taking some of the methods out of the clinic and closer to the public; this would place these methods at a point much more familiar to the common person who may be intimidated by the clinics and modern medical practices.

Also valuable would be a program which would involve the hakims in basic courses concerning nutrition, health and hygeine, stressing both the preventative and curative aspects of medicine. With such a background these traditional health practitioners could be of more service to the community. This could be sponsored by the Ministry of Public Health.

B. The Atar

The *atar* is another person whose trade is relative to community health. He is a shopkeeper who sells traditional medicines and has some knowledge of his medicines' properties. He does not diagnose illnesses or prescribe medicines except those that are very benign in nature; rather, he sells medicines to his customers on request. The sale of such is generally his sole source of income.

The medicines he offers are of an herbal, chemical and/or mineral content. The *atar* buys his medicines from distributors and may be involved in their mixing or preparation for sale.

There are known to be two types of *atars* - those who sell only health panaceas and those who also sell cooking spices and other odds and ends such as needles, thread, etc.

Five *atars* were interviewed in the cities of Kandahar, Herat, and Khanabad.

Personal Data:

Most *atars* begin working at a very young age. As soon as they are able to manage a shop after their father's or other close senior male relative's tutelage, they are given the responsibility to do so. As they do not attend school but rather take up apprenticeship in their father's shop, they may begin as an *atar* as early as ten years of age.

In accordance with what one might expect the *atars*, due to

no schooling and working as a shopkeeper at such a young age, generally cannot read nor write. However, they learn to speak the languages of their customers and thus usually know many tongues including those of Dari, Pashtu, and Urdu; those in the northern area of the country also know Uzbeki and Turkmani.

The majority of the atars in the country are Indian, many of whom are Sikhs. In the northwest, however, many of the atars are Turkoman. The large number of herbal medicine dealers in the Punjab of India offer an explanation of the source of this profession's Indian dealers.

As far as grouping these people into a class within the country they could be said to be within the shopkeeper class. Most atars are not wealthy people but make a modest living.

Professional Circumstances and Services:

The atar's working quarters usually take the form of a small shop centrally located in the bazaar or marketplace. In other cases the atar simply spreads his medicinal collection out on the edge of the street. His shop is well stocked with herbs, chemicals, and minerals. He keeps large supplies of herbs in paper bags. Small amounts are available in jars, cans, etc. to sell to the customers.

The herbs present in their shops have been gathered or purchased by other persons who bring these to the atar. He may also go to the atar bazaar to pick up more of his supplies. Some of the

herbs are only to be found in certain geographical regions and may come from as distant as India, Iran, Pakistan and the Arab countries. The *atar* also may sell herbs to *hakims* and often fills prescriptions of customers sent to him by the *hakim*.

The *atars* are known to remark that their profession is an important job and requires much attention and thought. They report that there are two critical requisites in the job of the *atar*; first, knowing how to use herbal medicines, and second understanding herbal medicine's characteristics. An *atar* should be able to distinguish one medicine from the other.

Recognition of the herbs: One *atar* explained that *atars* recognize medicines by their color, odor, taste and weight. This *atar* reports that it is essential to be able to recognize the herbs and the herbs as medicines in order to do their work, as some of the herbal medicines are very dangerous and may cause death. For this reason the atar must know the characteristics of the medicines. As an example, if *kusht-i-kochola* is confused with *kochola* (poison and killed poison - possibly arsenic) or *simab* (mercury), the *atar* could be responsible for the death of a customer as one form is poisonous and the other form is not.

The *atars* have a great quantity and variety of medicines in their shops. A range of examples includes: sulphur, mercury, arsenic, copper sulfate, tree sap, cucumber seeds, castor oil, ginger, anise, fennel, cardamon, turnip and carrot seeds, opium pods,

INDIGENOUS HEALTH PRACTITIONERS IN AFGHANISTAN

by

Anne Macey, Pam Hunte, Hassan Kamiab[1/]

I. INTRODUCTION

Throughout Afghanistan the majority of people who become sick and require medical treatment receive treatment from an indigenous medical practitioner who has received no modern medical training. The modern doctor/patient ratio is very low and at present the modern medical facilities are concentrated in the urban areas, largely in Kabul. The Ministry of Public Health is concentrating upon expanding its Basic Health Centers in the provinces so that modern facilities may become available to more Afghans. The Ministry recognizes, however, that it will be several more decades before adequate modern services can be provided by the Government throughout the country. Consequently some consideration is being given to alternative methods of delivering medical care and one possible channel is through the indigenous medical practitioners

---

1/ Anne Macey, Family Guidance Research Advisor; Pam Hunte, Family Guidance Research Analyst; Hassan Kamiab, Interviewer Supervisor, Family Guidance Section, Afghan Demographic Studies.

distilled herbs, pomegranate juice, wild rue and mosses. Their panaceas may also include any combination of substances. However, *atars* may only use those mixtures which are prepared by the *hakim*, or mix them according to the *hakim*'s prescription.

The *atars* do not diagnose a customer's illness. They refer the customer to the *hakim* for this service. They only accept the customers' prescriptions and fill them. They feel that most all their medicines do not have side-effects.

Some illnesses for which the *atars* distribute medicine are: colds, coughs, stomach complaints, bronchitis, head aches, rheumatism, fever, yellow fever, typhoid, malaria, paralysis, boils, infections, etc.

They do not have medicines for tuberculosis or heart disease and they do not do surgery or handle problems requiring surgery.

The *atars*' medicines may be sold in the dry leaf form of an herb, a powder form, a distilled liquid, syrup, oil, ointment, cream, tablet, etc.

Clientele of the Atars:

The *atars*' customers, both male and female, include people from every class within Afghanistan. One of the advantages of the *atars*' services and medicines is that they are inexpensive. Thus, many people who cannot afford going to a doctor and then buying their prescribed treatments from a pharmacy use the *atars*' medicine. The fee for a visit to a doctor is usually 20 afghanis and

medicine purchased from a pharmacy may cost from 100 to 500 afghanis.[1] Even those persons who have advanced educations use the atars' medicines for those cases in which they know the atars' supplies work or in cases where the doctors' services have failed and they have chosen to turn to the atars' medicines instead.

In those areas where there are no hospitals and pharmacies, the atars' medicines are commonly used. Patients themselves know what they need from the atar or they have received a diagnosis from an hakim and are picking their medicines up from the atar.

By the wide range of backgrounds of the atars' customers, it is evident that their services receive respect from the public. Their services are also frequently used indicating the active position the atar holds in the health medicine distribution procedure within the country.

Cost of Medicine/Services:

The atars' medicines are of little cost to the customer; a specific herb may cost a few afs and treatments usually cost 20 afs or less.

Most atars say their income is moderate. They do not become wealthy from this business. Their medicines are cheap and on the occasions in which a customer cannot afford to pay the small price the atar usually gives it to him free of charge. The atar also

---

1/ 1 afghani = 1.8 US cents at 55.5 afghanis to the US dollar, April 1975.

feels that he receives religious merit (sawab) in this way as in serving the public through his profession in general.

Position in the Traditional, Health Services System of the Country:

The atars are serving in a useful capacity through their distribution of indigenous medicines in the country - especially based upon the need displayed by their heavy customer load. There are not enough doctors or pharmacies to serve the population in the urban centers, much less in all of the rural areas, and many use traditional resources out of necessity. Others also doubt the value of modern medicine due to their traditional orientation or its prohibitive cost.

Thus, traditional medicine is at present the most common form of medicine used in the country and its distributors still perform a needed service.

Relationship to Modern Medicine:

The atars do not distribute modern medicines - no aspirins, etc. However, atars themselves are likely to use modern medicines in treating some of their own problems. For example, they may vaccinate all their children. They may send their wives to the hospital in the time of a difficult delivery or use surgery as needed. They are not opposed to modern medicine for certain cures. However, they also recognize the need for traditional medicines for certain treatments or certain sized pocket books. For those ailments which they profess not to be able to cure, they refer

their patients to modern medicine.

Relationship to Family Planning and Contraception:

Little information was obtained on this subject, but it is believed that the *atars* do not disapprove of family planning for the purpose of spacing or limiting family size. They are likely to be a good source for distribution of such items as condoms, and possibly creams or jellies. The *atars'* involvement in the distribution of these items could be based on the profit motive in accordance with the rest of their business.

Suggestions for Future Programs:

As mentioned above, *atars* could be involved in the distribution of family planning methods such as condoms, creams and jellies. Necessary of course would be some family planning educational courses; this could be conducted by the Afghan Family Guidance Association perhaps with a grant from US/AID.

The distribution by *atars* would save the Afghan Family Guidance Association clinics from experiencing patient overloads by taking some of the non-medically related methods out of the clinic and closer to the public; this would place these methods at a point much more familiar to the common person - who may be intimidated by the clinics and modern medical practices.

Also valuable would be a program which would involve the *atars* in basic courses concerning health and hygiene stressing both the preventative and curative aspects of medicine. This

could be sponsored by the Ministry of Public Health.

Atars would also be promising candidates to sponsor for literacy courses.

C. The Shikastaband (Bonesetter)

The shikastaband (bonesetter) in Afghanistan has an active business. In addition to setting broken bones he also deals with bone and joint problems.

Three shikastabands were interviewed in the cities of Kabul, Charikar, and Kandahar.

Personal Data:

Bonesetters are generally older men who have learned their skill through experience. This is not usually a family profession passed on from one generation to another. They do not usually train students nor were they students themselves.

Often a bonesetter has another occupation such as farming or shopkeeping; his service as a health practitioner he performs for sawab (religious merit).

The bonesetters with whom we spoke have been practicing their skills for decades. They are married men with large families. They are either illiterate or have been involved for a few years in home or mosque study.

Professional Circumstances and Services:

Bonesetters may have small shops or treat their patients in their homes. They perform the following services:

1. setting and binding broken bones
2. reducing dislocations
3. treating back pain by massage and pressure
4. treating sciatica
5. treating general body pain (in neck, back, legs, etc.)

Technique for setting and binding broken bones: Bonesetters manage to set bones mainly through the sense of touch; they carefully examine the area of the break and apply pressure as necessary to re-align the bone. They never use x-rays as no facilities are available to them.

After the bone has been properly aligned the bonesetter massages the injured region. On top of a clean piece of cloth is spread the yellows of two eggs; this poultice is then applied to the break and bound tightly into place. Sometimes pieces of thick carboard or wood are applied above and below the break; these are then bound into place for protection.

If the break is in the arm the patient is then given a sling. If the back or leg is broken the patient is told to rest and keep the break immobile.

The bonesetter recommends a specific time which the break should remain bound according to the patient's age. For example, if the person is 20 years old the bone should remain bound for 20 days; if he is 21 years old a period of 21 days is prescribed.

Regardless of age a minimum of ten days and a maximum of 45 days is recommended. This system is viewed as being better than that of the modern practitioner's technique which requires a longer healing period.

When the bonesetter removes the bandages he checks to see if the patient has any swelling or pain in the region of the break.

<u>Technique for reducing dislocations</u>: The bonesetter recognizes a dislocation by the presence of swelling in the joint region. He reduces the dislocation by pulling the limb until the bone is reunited with the socket. He then treats the region similar to that described above for broken bones. He binds the region in immobilize it for a period of time.

<u>Technique for treating back pain</u>: Individuals come to the bonesetter and tell him that the nerve in the lower back region has "turned over"; the bonesetter himself does not believe that this is actually the case but rather says that the condition occurs if the person has twisted his back or turned around quickly. Thus the nerve in the lumbar region swells a bit.

The swollen nerve is said to extend from the lower back to the ankle. He begins at the lower back and applies pressure to the nerve with his thumb and continues this to the ankle. The nerve at the base of the ankle is then pinched with his fingers and "lifted up".

<u>Technique for sciatica</u>: Male patients come to the bonesetter for relief from pains which extend from the hip region to the ankle; this is said to be a very uncomfortable condition. This is referred to as <u>araq-i-nesah</u> and is believed to be caused by having sexual intercourse while lying on one's side; it is also said to be caused by incomplete ejaculation.

Treatments for this condition vary; usually a few burns are

inflicted to the tendon region of the ankle.

Technique for treating general body pain (in neck, back, leg, etc.): Massages are frequently given to patients encountering such pain. A special condition, qaisari, which is said to result from the consumption of cold water after a period of heavy exercise, is treated by burning the upper back region in two places.

For all the above conditions special diets are often recommended by the bonesetter; torshi (sour or pickled foods), yoghurt, and dogh (buttermilk) are sometimes prohibited.

Clientele of the Bonesetter:

Patients are both male and female from all social classes. One bonesetter mentioned receiving three to five patients per day.

Cost of Services:

Generally the bonesetters receive five to twenty afghanis[1/] from each patient although some who are very famous may charge as much as 200 afghanis to set a broken bone with an additional 50 afghani fee for massage.

Position in the Traditional Health Services System of the Country:

The bonesetter in Afghanistan, where doctors and hospitals are few and far between, performs a valuable service. He is usually a respected figure in the community and is said to have a

---

1/ 1 afghani = 1.8 US cents at 55.5 afghanis to the US dollar, April 1975.

high rate of success in correctly setting broken bones. Many people have more faith in his techniques than in those of modern medical practitioners.

There are not many bonesetters in each community, however. There are usually only a few in each city and in the countryside three or four villages may share the services of one shikastaband.

Relationships With/Attitudes Towards Other Medical Practitioners (Traditional and Modern):

As far as their own health is concerned the bonesetters being of a traditional orientation, usually turn to traditional health practitioners for their problems. It is of course possible that if traditional treatment does not produce satisfactory results they may turn to modern medicine.

One bonesetter mentioned that modern doctors could not "fix bones" correctly at all.

Opinion of General Health of the Community in Comparison to the Past:

Some bonesetters express the belief that the health of their communities has improved; they also believe that it will continue to improve in the future.

Suggestion for Future Programs:

Bonesetters could be involved in basic courses concerning first aid, health, and hygiene; with this background these traditional health practitioners could be of more service to the community. This could be sponsored by the Ministry of Public Health.

who are already providing medical services, although additional training would be necessary. It might be possible to provide some basic training to indigenous practitioners, who have an interest and aptitude in providing medical services, so that their services may be more effective to their patients.

The objectives of this study are as follows:

1. To gain information about indigenous medical practitioners, the sources of their training, the size and characteristics of their clientele, what diseases they treat, most prevalent diseases observed by them, drugs and herbs they use, under what conditions do they refer patients, their general knowledge of causes of diseases, infection and contagion, their sources of information regarding new treatments (both local and modern), and other areas of concern to the Ministry to be worked out during further discussions.

2. To determine the characteristics and role of the indigenous practitioners in their communities.

3. To determine whether the indigenous practitioners are a potential channel for modern medical services, including mother and child health counseling and distribution of family planning services.

4. To provide the information mentioned above in a form useful to the planners of the basic health services so that they can make informed judgements about the potential use as well as

It would also be valuable to involve the bonesetters in literacy courses.

D. The Dalak (Barber)

The dalak (barber) is a jack-of-all-trades who provides valuable health services to his community. One dalak was interviewed in a small village near Kabul; this interview demonstrating his wide range of activities is presented in full:

SUBJECT: Interview With a Dalak (Barber)

DATE: February 1975

TEAM PRESENT: Kamiab, Said Nader Shah, Jaghori

We were referred to this dalak, or barber, by one of out drivers and spoke to him while sitting in the car; we found him to be friendly and cooperative.

He is thirty-five years old and illiterate. He began learning his skill when he was eight years old, studying under a famous dalak.

This profession is often an inherited skill. His father who is also a dalak is quite old and doesn't practice his skill much anymore. His son also learned many of his techniques from his father. The brother is also a dalak in the community.

This dalak has trained about fifteen students in his twenty-seven year career.

In addition to his work as a barber he also performs the

following services:

1. circumcising
2. blood-letting
3. tooth-pulling
4. treating khorasak (dyptheria/wheezing)
5. curative burning - cauterization
6. cooking (at weddings and funerals and preparing khairot, food given in the name of God)
7. town-crying (informs people about weddings and funerals by going house-to-house both near and far)

This dalak has no shop but treats people by going to their homes.

Information Concerning Circumcision:

Circumcisions are performed for boys from the age of two days to fifteen years. Usually they are performed when the boy is just an infant; at this young age the foreskin is very thin and the wound heals very quickly.

The equipment used is as follows:

1. alcohol
2. tel-i-sya (a substance made from sharsham (linseed oil) which is usually used as fuel for wick lamps)
3. surma chob or salaai (wooden tool used for applying antimony to the eyes)
4. nyak (reed) - the tip of this is slit and it is used as a clamp
5. poki (barber's blade)
6. manjila (a roll of white cotton material)
7. Cibazil powder or pomade (a modern germ killing medicine)
8. thread

First the dalak washes his hands and all of his tools with alcohol; the penis is also washed in alcohol.

Then tel-i-sya is applied to the penis. This is done for two purposes: (1) to make the skin softer, and (2) to serve as a guidline as far as where the cut should be made.

The surma chob is inserted under the foreskin up to the point at which he will cut. The skin is then held in place with the slit nyak clamp and the incision is made in between the surma chob and the nyak. A very sharp barber's blade (poki) is used. The nyak also serves to control the cutting.

Note: If the boy is young, the dalak says, "Look at the bird - up there!" This distracts the boy's attention when the cut is made. He is held down by a few people - usually his father or other relatives.

After this one drop of tel-i-sya is applied to the wound.

The manjila (narrow strips of cotton cloth) is then put like a ring around the penis to prevent injury. A bit of Cibazil powder or pomade is also applied to the wound.

The boy should eat liti, alwa, meat broth, and eggs; alot of roghan is also good. He should not eat beef, pepper, or pickled foods. Drinking cold water isn't good either.

The dalak said that he goes to check on the patient for two days. The boy is usually up and around after two days or so.

Complications: If the above prohibited foods are eaten an

infection may occur; in this case some potassium permanganate is combined with warm water and the wound is washed. It should be better in two or three days.

There are six veins in the penis. One is larger than the others (jelawak) and lies in the lower part of the penis; if this is cut by accident heavy bleeding occurs. If this occurs, the dalak clamps the vein with his fingers and ties it with thread. Some Cibazil powder is also applied.

Circumcision Celebration: Just before the circumcision is performed friends, neighbors, and relatives gather in the home and are guests for a full meal. The circumcision takes place in a nearby room. Handkerchiefs and candies are distributed to the guests and sometimes a band of singers is also present. The degree of elaborateness depends upon the family's economic situation.

The payment received for the circumcision also varies according to the socio-economic standard of the family. A rich family may pay the dalak 100 to 200 afs along with a handkerchief and some candies (nukel). From a poor family he probably only receives twenty or thirty afs along with the handkerchief and nukel. He accepts whatever the family gives him.

He couldn't tell us how many circumcisions he performs per month; it depends somewhat of course on the number of boys that are born in the community.

Seasonal patient loads very. Most circumcisions are undertaken in early winter during the time period of chil-i-khushk (forty days of dry winter) because the wound is said to heal faster due to the weather. Summer is a bad time because the wound is said to "get water" faster and infection occurs more frequently.

Information Concerning Blood-Letting

This dalak began to learn the techniques of blood-letting when he was ten years old; his father who is also a dalak taught him this skill. He himself has taught four students the techniques of blood-letting.

He treats men, women and children from his village. Whenever blood is let he first recites the kalima (beginning verse from the Quran) and washes both his hands and all the instruments used.

Adult blood-letting: A variety of techniques are used to free the body from "bad blood". Symptoms are varied; some conditions for which blood is let are lack of appetite and rashes. Many others exist also.

1. Free-flow bleeding:

   a. single cut of vein: Such an incision is always made following the direction of the vein itself:



CORRECT INCORRECT

A popular vein from which blood is let is the rag-i-aftandom (a large vein in the arm from which doctors usually take blood). This vein is incised with a poki (barber's blade) and the "bad blood" is allowed to freely flow. This blood is dark and thick. When the blood becomes lighter in color and thinner the treatment is completed. The dalak then binds the incision with a clean cloth.

b. numerous small incisions (galak): A different blade is used for this technique. This is called a nishtar, a small onesided razorlike blade. Cuts are made which do not penetrate as deeply as in the treatment above; these many cuts often draw blood from not one vein but many small veins directly under the surface of the skin.

Galak is used for the following conditions:

sorkh-baad ("red wind") - This is a facial skin disease in which large red blotches appear on the cheeks; the face is also puffy. Numerous superficial incisions are made on the face and the "bad blood" is taken.

araq-i-nesah - This is a condition found only in males. It is caused by having intercourse while lying on one's side which causes ejaculation to be incomplete. A vein from the hip region to the ankle causes severe pain.
First the dalak follows the vein from the hip to the ankle with his thumb and thus locates the correct area from which to take the blood. Numerous small cuts are made on the back of the ankle with a nishtar. A bit of foam is first to appear and this is followed by some yellow liquid. When a small amount of blood ("one or two drops") appears the blood-letting is complete. Following this the cuts are wrapped with a clean piece of cloth. This treatment relieves the pain.

2. Kadu shondan (blood-letting utilizing a kadu - small gourd)

Blood is usually taken from the upper pack region between the shoulders. On the dry skin galak (numerous small cuts) are made with a nishtar and on top of these a kadu (small gourd) is applied.

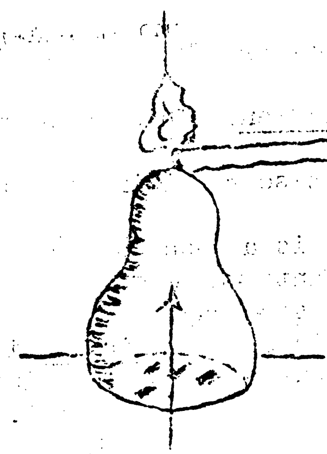
This gourd has an open end which makes contact with the skin; a vacuum is formed within the gourd.

A small piece of cloth is then formed into a wick. This is soaked in roghan-i-zard, held to the closed end of the gourd, and lit. The air within the hollow gourd is heated and as it contracts the skin is pulled up along with increasing the bleeding from the galak.

Note: This dalak believes that the kadu (gourd) itself pulls out the blood with a power of its own.

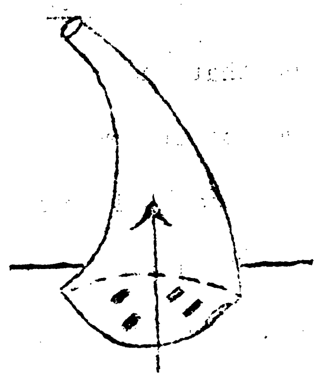
When the gourd is full of blood it is removed from the skin and emptied. This process is repeated two or three times until the blood is light red in color. Then the blood is sof (clean) and the treatment is complete.

The patient shouldn't eat beef, pickled foods, or pepper after this blood-letting. (Note: This is a general dietary prohibition following all types of blood-letting.)



3. <u>Shokhak</u> (blood-letting utilizing a cow horn)

This procedure is the same as for <u>kadugak</u> but in place of a gourd a <u>shokh</u> (cow horn) is used. This is hollow and open on both ends. The large end is pressed against the skin between the shoulders on the back and over the <u>galak</u>. The blood is then sucked up into the horn from the pointed end.



The horn is filled and emptied two or three times until the blood becomes light in color and <u>sof</u> (clean).

Note: <u>Jats</u> (gypsies) often use an iron horn-shaped tool to perform this treatment; they are famous blood-letters.

<u>Blood-letting for children</u>: This dalak mentioned the following childhood ailments as also requiring blood-letting:

1. <u>boghu</u> - This is a rash on the upper thigh region found in infants who are two to three days old. A vein which stretches from the thigh to the soles of the feet is bled. A <u>nishtar</u> is used to make very superficial cuts (like scratching of a vaccination) on the soles of the baby's feet. The skin is then pinched and a small amount of blood is pressed out.

2. <u>pit</u> - This is a generalized rash on all parts of the body; it burns and itches (an allergy?). The <u>rag-i-aftandom</u> of the arm is cut (see above) with a <u>nishtar</u> rather than a <u>poki</u> because the child's

vein is smaller. The "bad blood" is thus removed.

3. sina-i-baghal (bronchial pneumonia) - Shokhak is performed (see above).

The dalak receives two to ten afs for these various bloodletting techniques.

Concerning Jats (gypsies) and their techniques, this dalak had the following comment: "Jats know their skill of bloodletting very well, but they're dirty - not like me."

Information Concerning Toothpulling:

When this dalak was fifteen years old his father taught him how to pull teeth. He has taught three students this skill himself.

He said that this was a very important skill and that it was very difficult to perform correctly. Teeth are pulled only when absolutely necessary. (Note: An example of this dalak's perception of his role and status...)

All of his patients are from his village; they don't have enough money to go to a dentist and thus they come to him.

An ambur (pliars for pulling out nails from wood) is used to pull the tooth.

The patient should gargle with cold water after the tooth is pulled and then a bit of cotton is applied to the cavity; the cotton serves to stop the bleeding.

No special diet is prescribed, but the patient is told to drink large quantities of cold water.

This dalak believes that maswaq (a stem of an unidentified

the limitations of these indigenous practitioners.

5. To continue training of Ministry personnel in research methods so that similar studies may be undertaken by the Ministry in the future as they require them.

II. SURVEY RESULTS

In the Afghan Family Guidance Association Client Follow-Up Study, a survey which compared clinic clients, their non-client neighbors, and the husbands of these women, it was asked of all respondents what medical practitioners (both traditional and modern) they had visited in the twelve months previous to being interviewed. Results are shown below:

TABLE 1

Proportions of Clients, Non-Clients, and Their Husbands Who Have Visited Various Medical Practitioners During the Past Year for an Illness

Practitioner Visited:		Percentages			
		Clients	Non-Clients	Client Husbands	Non-Client Husbands
Mullah	Traditional	30.0	31.9	6.7	11.1
Hakim	Traditional	8.5	10.4	5.4	9.5
Shrine	Traditional	26.1	27.4	9.8	15.7
Dai	Traditional	10.0	9.9	3.8	2.5
Nurse	Modern	64.4	23.4	6.3	3.9
Doctor	Modern	82.2	69.6	65.2	66.0
Pharmacist	Modern	30.7	21.7	33.9	31.2
Number of Respondents		1050	905	864	693

tree) is much better than a toothbrush for cleaning teeth. This root is hit with a stone on one end until it becomes a soft brush-like tool. He said that a modern toothbrush injures the gums and removes the enamel from the teeth.

Note: To use *maswaq* incurs *sawab* (religious merit). To use a modern toothbrush is believed to be a sin..."who knows what kind of bristles are used to make a toothbrush?"

This *dalak* has had eight of his teeth pulled; all were removed by a dentist. Some he had removed when he was a soldier by the army dentist. His father who is also skilled in toothpulling wouldn't remove his son's teeth because he said that he became nervous and his hands shook when treating members of his own family. (Note: This can be compared to *dais* who refuse to deliver their grandchildren for similar reasons, *mullahs* who refuse to make *tawiz* for their family members, and modern doctors who refer members of their family to other doctors...)

Information Concerning the Treatment of *Khorasak*:

Khorasak is a serious case of wheezing (perhaps dyptheria) that occurs often in children. Sometimes it is brought on by eating a large quantity of HOT foods like walnuts or pine nuts.

A section of the epiglottis is thought to "go up" and the windpipe is obstructed. A rasping sound occurs every time the individual takes a breath.

This *dalak* washes his hands and then puts two fingers down

the throat of the patient; the section of the epiglottis is "pushed down".

After this a vein on the top of the patient's head is cut with a poki; then on top of the head is placed a white onion which has been peeled and squashed. The onion is tied into place with a scarf knotted under the chin.

This treatment is said to clear up any wheezing.

Note: Sometimes the patient is also instructed to drink ab-i-chilam (the water from a waterpipe); this is also drunk by pregnant women (refer to dai reports).

History of Profession:

The dalak told us this story:

"One of Mohammad's close followers was named Salmon. Once as they were gathered, three objects came down from heaven: a mirror, a comb and a scissors.

Mohammad said to the people that were assembled that whoever would be best complimented by the three objects should take them as his own. All of the men tried and they found that they fit Salmon the best.

Thus Salmon first cut Mohammad's hair. To prevent it from falling on the ground Salmon ate it. When Mohammad saw this he told him to stop - since this was the first haircut ever given and a precident would be set all following generations would have to eat the hair too. Then Salmon disposed of the hair in a clean place.

Note: Today this dalak is careful how he disposes of the hair he cuts. He collects it and then buries it in a clean place.

General:

This dalak believes that people have a need for him and appreciate his work because he is present at and participates in important events in their lives. (Note: Such rites of passage include circumcision, weddings, funerals, etc.)

He also mentioned that his work holds much sawab (religious merit).

When we asked him if his work load had changed over the years he said that at present he has many more people in need of his services as a barber than in the past. People these days are more concerned with fashion and rather than have their hair cut only one time a month as before they now have their hair cut two or three times per month. (Note: This fashion in the village is not the same as that of Kabul where long hair in males is the mode.)

He believes that the general health of the village is worse today than before; he attributes this to economic problems and the lack of good food.

He thinks that the population has grown in recent years and says that this is due to the fact that people are now marrying at an earlier age.

Concerning modern medicine he thinks that it is widely used but that it is highly expensive. He also said that much of the

medicine is fake. Doctors were also said to not be very intelligent.

Suggestions for Future Programs:

The dalaks could profit from a basic course in health and hygiene, such as one that could be conducted by the Ministry of Public Health.

Dalaks could also benefit from literacy courses.

E. The Dai: The Traditional Birth Attendant

The traditional birth attendant in Afghanistan is known as the dai. She is generally available in all settled areas and figures[1] show that she is responsible for delivering the highest percentage of the infants in the country.

She is generally thought of as an older woman who has learned her profession from the assistance of other traditional birth attendants. Most of the dais perform the work they do from economic necessity but benefit also be receiving religious merit from the nature of their work.

Data concerning dais was obtained through a variety of research efforts. The first data was gathered during preliminary interviewing for an Afghan Family Guidance Association Clinic Client Follow-Up Study.[2] Further quantitative detail was then gained from the first round of this survey.[3] In order to obtain more detailed information of the dai, her practice and her clients a survey of an open-ended form was conducted. Interviews from

---

1/ Refer to Report No. 10: The Dai: Traditional Birth Attendant in Afghanistan by Anne Macey, Pam Hunte, Mahbouba Safi, June 1975.

2/ Afghan Family Guidance Association Clinic Client Follow-Up Study Pilot Study Report - Report No. 15 by Anne Macey, Pam Hunte, Mahbouba Safi, and Hassan Kamiab, June 1974.

3/ AFGA Clinic Clients and Their Husbands Compared with Non-Client Neighbors and Their Husbands by Graham Kerr, Anne Macey, Pam Hunte, Mahbouba Safi and Hassan Kamiab - Report No. 12, June 1975.

forty dais and fifteen dai clients[1] were completed and a separate report based on these was written and prepared for this report series. (Refer to thi dai report for a detailed presentation of the dai and her role as a traditional birth attendant in Afghanistan.[2])

A very brief description of the dai will be presented here, as more detailed information is available in the above mentioned report.

Personal Data:

The average age of the dais interviewed (40) was 60.6 years, indicating a correct assumption by other respondents that the dai is an older woman. She is one who has not had any formal study and none of the forty dais interviewed were literate, although a couple were able to read passages from the Quran but not able to write.

Of the dais interviewed thirty of the forty were widowed and most all were noted as being below average or very poor economically. Thus the idea that the dais perform their work out of necessity (for financial reasons) is well supported by the figures as well as by their own statements.

1/ Dai and Dai Client Interviews by Pam Hunte, Anne Macey, Mahbouba Safi - Report No. 16, June 1975.

2/ Refer to Report No. 10 - The Dai: Traditional Birth Attendant In Afghanistan by Anne Macey, Pam Hunte, Mahbouba Safi, June 1975.

The *dais* were all family women. It was found that they had had an average of 9.7 pregnancies themselves and at present an average of 3.9 living children.

The Dai and Her Practice

Frequently the *dais* are following a precedent set by past generations of their families and have learned the profession from mothers, grandmothers, aunts or other family members. Some women had been present at numerous births and had therefore learned the skills of midwifery through observation. These women were either working out of financial need, the desire to help and/or the religious merit involved.

Among the *dais* with whom we had spoken some had been especially active and had delivered from 1000 to 4000 babies in the span of their careers. Most all had delivered well over a hundred babies. The average number of years spent as a *dai* was over twenty years.

Generally the *dais* begin their services with pre-natal care. During this period they may be involved in such activities as giving abdominal massages, dietary advice and miscarriage prevention advice as needed. They may also be able to detect a multiple birth or the sex of the unborn for the expecting mother.

At the time of the delivery the *dais* are called to come to the delivering woman's house. She will help the woman with her delivery and care for the newborn child before returning to her

own house. Some dais have the habit of staying on to help the mother and child for a few days while others may return daily to lend assistance. Some dais mentioned do little to no work after the actual delivery day.

Most dais recommend the squatting position for delivery. At this time the dai may take her position behind the woman to help support her during the delivery. Some dais, however, prefer that the woman sit on the dai's legs; others recommend she sit on a pile of bricks while the dai assists by squatting before her in position to receive the infant.

As soon as the baby has emerged the dai takes it and then waits until the placenta has been expelled before tying and cutting the umbilical cord. The dai may then assist in the washing of the infant, feeding him a type of laxative substance to clear the digestive tract, binding the navel wound and then setting him aside while she tends to the mother.

The dai usually worries about the delivery until the time that the placenta has been completely expelled. She may use religious amulets (tawiz) or other magico-religious elements to insure the safety of all at this tense time. The placenta is generally buried with special rites being applied at this time to enhance the mother and/or child's well being.

In the event of an especially difficult delivery the dai may resort to one of her many panaceas or may quickly call for

the assistance of a modern medical practitioner, such as a doctor or nurse-midwife where they may be available.

Other than those services already mentioned the <u>dai</u> serves as a main counsellor in indigenous methods of fertility regulation (see separate report on this topic[1/]). Women come to her mostly for methods to induce fertility but also for inhibiting fertility and inducing abortions (although the latter is forbidden in the country).

<u>Clientele</u>:

Modern medical services are generally available in the main urban centers of the country. Those women of the community who prefer the modern services and who can afford them frequent the hospitals for their deliveries. The remainder of the communtiy depends upon the services of the <u>dais</u> or other local persons who have some experience in midwifery, such as an older woman or a neighbor.

The family of the woman delivering generally prepares all the supplies needed for the delivery, as requested previously by the <u>dai</u>.

The clientele of the <u>dai</u> are typically from the same neighborhood and have gotten to know the <u>dai</u> before the actual time of the delivery. Many women continue to use the same <u>dai</u> for

---

1/ Indigenous Fertility Regulation Methods by Pam Hunte, Anne Macey, and Mahbouba Safi, June 1975 (Report Series No. 8).

all their deliveries when they have been satisfied by her services.

Many women prefer to have their deliveries at home and are therefore more inclined to enlist the dai and plan for her assistance ahead of time.

Cost of Services:

Many of the dai's clientele chose to use her services due to the modest cost of her assistance. The dai does not request payment from her clientele but an amount understood as appropriate for the communtiy is usually paid. Those who can afford to pay more do so and some who cannot afford to pay anything receive the services from some dais free of charge. The average price for pre-natal care, however, is about ten to twenty afghanis[1] and for the delivery is about 150 afghanis. Nurse-midwives and doctors receive approximately four to six times this amount for only delivery services.

Relationships With/Attitudes Towards Other Health Practitioners (Traditional and Modern)

The dais are basically traditionally oriented people. However, in general they do not refuse the advantages of modern medicine and most have been to doctors for care. They more typically send their children to doctors for fevers, vaccinations and other serious problems, but do not go much themselves.

They do have cause to use their services, however, in the

1/ 1 afghani = 1.8 US cents at the rate of 55.5 afghanis to the US dollar, April 1975.

TABLE 2

Proportion of Respondents Reporting That They Took Their Children to a Medical Practitioner During the Last 12 Months

Practioner Visited By Child:		Percentages Clients	Non-Clients	Client Husbands	Non-Client Husbands
Mullah		35.9	36.2	14.2	18.8
Hakim	Traditional	9.1	9.4	4.8	6.5
Shrine		23.1	23.8	8.5	11.5
Dai		5.7	3.4	3.4	3.2
Nurse		5.7	3.7	19.3	8.1
Doctor	Modern	87.5	82.3	83.1	78.4
Pharmacist		40.3	34.5	30.4	26.4
Number of Respondents		1050	905	864	693

The modern medical practitioners received a higher attendance percentage in general than those who are traditional. It must be remembered, however, that this survey was carried out in five urban centers of Afghanistan where modern medical facilities are more readily available than in the towns and villages where often there are none.

In addition, our teams of interviewers presented quite a modern appearance and stated that they were associated with the Ministry of Public Health; this undoubtedly caused some respondents to not mention visits to traditional health practitioners due to embarassment or fear.

Women in general seem to turn more frequently to traditional sources than do their husbands. Mullahs and shrines are the most popular sources of aid in the traiditonal category while doctors

line of their professional duties. When they encounter a difficult delivery case they typically refer the patient to the doctors or nurse-midwives for further assistance.

Most dais frequent the shops of hakims or atars. They purchase herbal and other Greek medicines from these people for themselves and also for their clientele. They reported using the services of a bonesetter more frequently than doctors and also felt that the dalak, traditional blood-letter, did superior work to most doctors. The benefits of tawiz (religious amulets) are generally appreciated at every birth.

Most dais were aware that there was something available from doctors and nurses offered to women to help them inhibit further pregnancies (pills, loops, creams, condom, etc.). However, most of these dais had a negative opinion of these methods as they all seemed to know of cases where the women had received severe side-effects and could only focus on the draw-backs of these methods. They did comment, however, that if there were no harmful side-effects with these methods they too would be in favor of them, even to the point where they said they could work in a program to distribute contraceptive methods, providing they did not hurt the women.

Suggestions for Future Programs:

Programs of basic midwifery, hygiene and nutrition would be most beneficial to the dais. Certificates showing their achieve-

ments would also be of use to them. These programs could be given by both the Ministry of Public Health and the Afghan Family Guidance Association. Important clues as to the key time for referral to modern medicine in times of emergency might also be added to the midwifery course.

A course of literacy was mentioned by some as being useful.

A course informing the dais of what modern contraceptives are available and how they are used, etc. would be of service to them and the community, as they could then be sources of information as well as aids to family guides.

A program in which the dais are trained as family guides of the Afghan Family Guidance Association, and then used as contraceptive distributors as well as for family planning information and other services would be useful.

F. The Tawiz-Maker (Amulet-Maker)

In addition to the other indigenous health practitioners previously discussed there are also those persons whose profession deals with the psychological problems of their clients. They generally treat their patients by preparing special amulets (tawiz).

Most of these amulet-makers are mullahs (Islamic religious leaders) or other strongly religious persons such as sayeeds (descendants of the prophet Mohammad) or malangs (religious ascetics); some Indians (Sikhs) are also involved in the making of amulets.

Among these individuals, both Afghan and Indian, there are also those involved in the practice of jaadu (black magic); according to the Muslim religion, however, this is said to have a sinful connotation.

The following data is based on interviews conducted with four tawiz-makers in the cities of Kabul (three interviews) and Khanabad (one interview).

Personal Data:

Tawiz-makers are found in all regions of Afghanistan. They are literate individuals who generally speak Farsi or Hindi as a first language. The Muslim tawiz-makers have studied in mosque schools and later have taken up specific courses of five years or more to learn their skill in writing amulets. Many are following

the profession practiced by preceding generations in their families.

They begin writing tawiz when they are middle-aged and continue to do so for the rest of their lives. One tawiz-maker mentioned that this profession has been in his family for twenty generations.

They generally are married and have large families in keeping with the old Quranic ideals.

Professional Circumstances and Services:

Most tawiz-makers perform their work in their homes and have no special shops; they are famous members of the community.

Use of the amulets: Amulets are usually given to patients for one of the following reasons:

a. curing illness - Amulets are given for 72 specific groups of diseases; they believe that with God's will the patient's ailment will be cured. The patient himself must have faith in the amulet's power or else treatment will not be successful.

b. impotence - Special amulets are said to "open" the male who is suffering from this disorder.

c. inducing or inhibiting pregnancy - It is believed that with God's will a woman's wish concerning pregnancy will be granted if she possesses a special amulet for this purpose.

d. relations between two people - An individual may obtain an amulet to win the heart of someone he wishes to marry. A woman may obtain an amulet to cause her husband to lose interest in another wife or lover. Such amulets' use is not condoned by the Quran and is thus said to be sinful; the practice, however, continues.

e. protection from jinns (spirits) - Individuals, especially pregnant women and small children, wear protective amulets to ward off any harmful jinns (spirits).

Source of the amulets' inscriptions: The Quran itself contains specific verses that aid in solving health problems. In addition, the books of Majmuadaawat Kabir and Antroli also contain some verses. The Muslim tawiz-maker prepares amulets which contain inscriptions taken from these sources. In order to not deface the Quranic verses he writes the verses backwards.

The Indians involved in tawiz-making have other special books written in Hindi for their source of inscriptions.

Form of the amulets: The tawiz is usually quite small in size which allows for easy wearing; it is usually worn on a string around one's neck or pinned to one's clothing. The inscription is written in ink or blood on a small piece of paper which is then wrapped up in a small pouch made of leather or cloth; often the pouch is made up of many layers.

In addition to this general form of tawiz others also exist. Sometimes the tawiz-maker writes in blood directly on the patient's forehead or palm, or writes on an egg which the patient later consumes.

In other cases he writes in ink on a small piece of paper which the patient later soaks in water; the resulting liquid is then drunk. This treatment is called shuist. Also dudi (smoke treatment) is sometimes assigned; pieces of inscribed paper are

burned and the smoke inhaled.

Preparation of the amulets: After the tawiz-maker has spoken with the patient concerning his problem a special procedure in the tawiz preparation is undertaken.

He first obtains the name of the patient and his or her mother's name. He then changes the letters in the two names to a special system of corresponding numbers. This is referred to as abjad counting. As he matches the letters with their numbers a process of elimination takes place and finally only one letter and corresponding number remain.

This number represents a certain month for the tawiz-maker which signifies his patient's personal horoscope or fate. The month indicated has a corresponding sitara (star) or planet with characteristics which affect the patient's life.

The months have corresponding symbols and are divided into four groups of elements: dust, wind, fire and water. The patient's month and corresponding element are referred to as his fate or fortune. If, for example, a patient's element is dust the tawiz-maker will inscribe his tawiz in dust.

The days of the week also have significance in the preparation of tawiz. Sunday, the day of Jupiter, and Wednesday, the day of Mercury, are the best days to prepare tawiz; these two planets, referred to as sitara (stars) by the tawiz-maker, are thought to be most powerful and thus able to influence the strength of the

tawiz.

The hour of the day is also important. For example, *tawiz* for loving and liking should be written after 1:00PM on Mondays and Wednesdays. Jupiter rises and sets at this time of day, thus making the amulet more effective.

Clientele:

Tawiz-makers appear to be very busy; one mentioned that he had fifteen to twenty patients come to him daily and another said that on favorable days he had 40 to 50 patients coming from all twenty-eight provinces of Afghanistan. Men, women, and children compose the *tawiz-makers'* clientele.

Cost of Services:

The cost of an amulet depends on its purpose. Amulets obtained for headaches and other general ailments may range from ten to fifty afghanis. Amulets obtained for love or hate may cost as much as 1000 to 5000 afghanis, or as much as the patient wants to give.

If the patient is very poor and thus cannot afford to pay the suggested cost the *tawiz-maker* will accept whatever sum he is able to give.

Relationships With/Attitudes Towards Other Medical Practitioners:

The traditionally oriented *tawiz-maker* does not generally favor modern medicine and does not refer his patients to modern doctors. He and his family rely mostly on the services provided

by other traditional health practitioners such as the _hakim_, _atars_, _dalaks_, _dais_, etc.

One individual interviewed said he thought modern doctors were very helpful; he had gone to a doctor for his health problems.

Suggestions for Future Programs:

The _tawiz-makers_ are a prime source through which to explore the various types of psychological problems encountered by Afghans. As the study of psychology further develops in Afghanistan, it would be valuable to involve these knowledgeable individuals in its study.

IV. CONCLUSION

From the above data it is evident that the indigenous health practitioners in Afghanistan, both male and female, still continue to play a large role in the country's health system.

These are human resources that should not be forgotten. With proper guidance and training these practitioners could become better equipped to serve their communities' needs and thus further the general health of the population of Afghanistan.

بەسلسله نشرات تحقيقا تـــى
انجمن رهنما يی خانواده :نشريه‌شماره (۱۳)

طبابت محلی در افغانستان

پروژهٔ مطالعات دیموگرافی

انجمن رهنمای خانواده

کابل ـ افغانستان

جوزا ـ ۱۳۵٤

were most often visited in the modern category.

III. INTERVIEWS WITH VARIOUS INDIGENOUS HEALTH PRACTITIONERS

Structured open-ended interviews were carried out in depth with a variety of indigenous health practitioners in Afghanistan. The practitioners visited were:

1. hakims (traditional medicine practitioners/ distributors)
2. atars (traditional medicine distributors)
3. shikastabands (bonesetters)
4. dalaks (barbers/circumcisors)
5. dais (traditional birth attendants)
6. tawiz-makers (amulet-makers)

All of the above individuals play a role in Afghanistan's indigenous medicine system.

Interviews were carried out during 1974 and 1975 mostly in the urban regions of the country. Distribution of interviews is shown in the table below:

TABLE 3

Number and Location of Interviews With Indigenous Medical Practitioners in Afghanistan

Type of Medical Practitioner	Location: Kabul	Charikar	Kunduz	Khanabad	Kandahar	Herat	Total
Hakim	1	4	-	2	1	3	11
Atar	-	-	-	2	2	1	5
Shikastaband	1	1	-	-	-	1	3
Dalak	1	-	-	-	-	-	1
Dai	6	3	6	-	10	12	40 1/
Tawiz-maker	2	-	-	1	-	-	3
Total	11	7	6	5	13	14	63

Summary reports are presented for each category of indigenous health practitioner on the following pages.

1/ There were three dais interviewed in Mazar-i-Sharif.

A. The Hakim

The hakim in Afghanistan is a curer of medical ills who diagnoses and treats his patients through traditional techniques and medications. He is a highly trained medical practitioner. His medicines consist of herbs, chemicals and minerals of which he mixes and prepares for use.

In cases where the hakim does not have the medicinal ingredients himself he prepares a prescription and sends his patient to an atar (See page 17) to pick up the substances.

For this study eleven hakims were interviewed in the urban centers of Kabul, Charikar, Khanabad, Kandahar, and Herat.

Personal Data:

Five of the hakims interviewed were Muslim and six were Indian (Sikh); many of the hakims' medicines come from the Punjab and other regions of India and the Sikhs form a large proportion of the hakims of Afghanistan.

These men had worked from 13-45 years in their profession. Most were from families whose male members had been involved in the profession for two to seven generations.

Hakims begin their apprenticeship in the shops of their fathers at a young age. As the apprenticeship takes so long most hakims who work independently are middle-aged or older; the young hakim may not be accepted by the community who may doubt his knowledge if he is too young.

Hakims are educated and can read and write. They obtain their education from either their father or uncle, from mosque schools, or from public elementary schools. Some have also studied abroad in India or Pakistan at special schools for *hakims*. Some of the Hindu *hakims* studied at the Ajmal Academy in Lahore; this also contains a factory where 98 *hakims* are involved in drug preparation.

Many medical texts, some very ancient, are studied by the *hakims* and used as reference books for treatments. These books contain information concerning Greek medicine (*dewa-i-unani*) or that of the Ayurvedic school of India. They are written in Arabic, Farsi or Urdu. The *hakims* preserve these texts very carefully as they have become a rare item and cannot be found in most bazaars.

Due to the fact that the *hakims*' patients come from a variety of ethnic groups, the *hakims* themselves are also multi-lingual. Farsi and Pushtu are basic; the Indian *hakims* speak Urdu and Hindi as well. These Indian *hakims* read and write in Urdu while the others read and write in Farsi.

These medical practitioners are not involved in any other form of employment; their work as *hakims* fills their time and is their life-time profession.

Professional Circumstances and Services:

The *hakim*'s customers usually find him in a small shop which is filled with his many medicinal preparations; in some cases he may perform his work at home.

<u>Hakims</u> know about germs. They say people become sick as a result of germs rather than from hot or cold weather as some people believe. <u>Hakims</u> also use their knowledge of the humoral content of foods in their treatments. They say some foods are hot (hot onions) and some are cold (such as green peas which cause gastric problems). Hot foods may be responsible for such diseases as jaundice and typhoid; the cold foods may cause paralysis. Special diets are usually recommended for the <u>hakims</u>' patients.

<u>Recognition of diseases</u>: The <u>hakim</u> diagnoses a person's disease by examining his eyes and tongue and feeling his pulse as well as by what the person tells of his problems. He compares the patient's pulse with a pigeon's which is warm and a hawk's which is cool. The <u>hakim</u> touches the patient's fingertips; the pulse of each finger has a separate name in his language. For example, the index finger is a pigeon's pulse and the middle finger is the hawk's pulse.

The <u>hakims</u> say they can cure the following diseases: cramps, colds, gastric problems, gonnorhea, pneumonia, fever, impotence, general weakness, rheumatism, cough, heat exhaustion, nervous problems, boils, constipation, paralysis and others.

The diseases they say they cannot cure are: heart diseases, epilepsy, tuberculosis, and those problems which require surgery.

<u>Medicines used</u>: The medicines used are often referred to as Greek (<u>Unani</u>) medicines. There are about ten different types: seeds,

flowers, kernels, syrups, extracts, pills, distilled liquids, compounds, oils, powders, ointments, pomades are among these.

It is said that in general the Greek medicines do not have side-effects. However, the _hakim_ must be careful with a few forms of their medicines. Mercury, arsenic, etc. may be dangerous in one form and be useful as a treatment in another form (the "killed" form). If these forms are not prepared properly they may cause health problems such as skin diseases, disorders in the blood and also shorten life.

The _hakims_ prepare the medicines themselves. They do not trust others to do thos work for them.

Their shops are well stocked with these medicines and they are stored in an orderly fashion. The _hakims_ store their prepared or unprepared medicines according to categories for easy reference. There are generally fifteen major classes (_bab_ = class): distilled liquids, _sofoof_, _atrifal bab_, _jawaresh bab_, _hob bab_, _khamira bab_, _roghan bab_, _halwaiyat bab_, _majoon bab_, _marham bab_, _moraba bab_, _koshta bab_, _qatra bab_ and pills.

After the diagnosis the _hakim_ gives the medicine he has prescribed to the patient; tells the patient how to use it and often recommends a special diet too. According to their knowledge some foods are not good for the patient and they therefore advise against them.

As an example of the medicines and treatments given for certain

Miscellaneous

62

INDIGENOUS MEDICAL PRACTITIONERS IN AFGHANISTAN

Afghan Demographic Studies
Afghan Family Guidance Association
Kabul Afghanistan

Family Guidance
Research Report No: 13
June, 1975

دولتی مطبعه

Afghan Demographic Studies
Afghan Family Guidance Association
Kabul, Afghanistan

INDIGENOUS HEALTH PRACTITIONERS IN AFGHANISTAN

by

Anne Macey, Pam Hunte, Hassan Kamiab

<u>Cooperating Institutions</u>

Afghan Family Guidance Association

State University of New York

United States
Agency for International Development

Family Guidance Research
Report Series No. 14

June 1975

TABLE OF CONTENTS

PREFACE

Afghan Demographic Studies presents Indigenous Health Practitioners in Afghanistan as one of a series of family guidance research reports which describe studies conducted with the cooperation of the Afghan Family Guidance Association.

Topics covered in other reports include a comparison of Afghan Family Guidance Association (AFGA) clinic clients and their husbands with non-client neighbors and their husbands; a comparison of continuers and dropouts from AFGA clinics, a study of 1200 randomly selected clinic records; a knowledge attitude and practice (KAP) study of the entire AFGA staff, a KAP study of Afghan pharmacists, a description of the commercial distribution of contraceptives in Afghanistan, a report describing the development and implementation of a new client information system for AFGA clinics, a report of a national KAP survey concerning family planning behavior, a study of the indigenous fertility regulation methods in the country, and a specific study concerning dais (traditional birth attendants).

For this report,about the indigenous health practitioners data was collected in a variety of ways. During the initial pilot study phase of the AFGA Client Follow-Up Study in 1973 qualitative data was gathered from a number of practitioners. Later during the first round of interviews in the study itself (1974) interview schedules contained question concerning indigenous health practitioners and quantitative data was assembled. Further intensive interviewing was done of the practitioners themselves and some of their clients.

The data collection methods are discussed herein as ADS hopes that by presenting the methods we will be able to help Afghan investigators who wish to conduct future surveys concerning related topics.

Afghan Demographic Studies is a joint project of the Afghan Government and the United States Agency for International Development, which is partially financed through a technical assistance contract with the State University of New York. It is based in

the Central Statistics Office of the Prime Ministry and, regarding the family guidance studies, has worked in very close cooperation with the Afghan Family Guidance Association and the Ministry of Public Health.

Graham B. Kerr, Ph.D.
Chief of Party
SUNY Advisory Team - ADS

Kabul
June 1975

ACKNOWLEDGEMENTS

Afghan Demographic Studies wish to thank the Ministry of Public Health for their authorization for the conduct of this study of indigenous health practitioners and also for providing counterparts to work with the advisors throughout the study.

The Ministry of Planning and the Central Statistics Office are thanked for providing office space and basic facilities required for the conduct of the work.

On a personal level, the authors would like to thank Madame Nazifa Ghazi Nawaz, President of Afghan Family Guidance Association; Dr. Abdul Ghioss Mukhamel, Advisor to the Ministry of Public Health; and Dr. Saxon Graham, Director, SUNY Advisory Team, for their constant interest and encouragement during long hours of discussion about this and related family guidance studies.

A special note of appreciation goes to Dr. Amir M. Mohebzada, Director, Information and Education Section, Afghan Family Guidance Association, who acted as liaison between the Afghan Demographic Studies and the Association, and also introduced the field teams to the appropriate authorities in the towns where the work was carried out.

A special note of thanks goes to Mr. Kohsar who identified many of the substances used in the indigenous methods. We would also like to thank Mr. Kohsar and Mrs. Belquis Shah for assistance with translations.

Mention of much thanks also goes to the fine quality of interviewing assistance given by Mr. Said Nader Shah and Mr. Jawghory.

Mr. Sayed A. Jalalai, Coding and Quality Control Supervisor of the Data Processing Section of Afghan Demographic Studies is thanked for his assistance with the development of the interview schedules and codebooks for the client follow-up study, of which part is reported in this survey.